# Administrator Perceptions of Advanced Practice Nursing Barriers to Practice

DNP Final Project

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By

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## Abstract

The purpose of this DNP project was to identify non-physician executive leaders' perceptions of barriers to APN practice at a large academic medical center in the Midwest. The project was a survey design. The survey was designed to identify the non-physician administrator's knowledge of key barriers of APN practice, including topics related to APN role and satisfaction with practice. The setting included a general inpatient hospital, oncology, psychiatry, and cardiology specialty hospitals, and outpatient ambulatory care settings, where approximately 550 APNs were employed. Non-physician executive leaders including business and nursing administrators and managers made up the sample. The sample included 143 email addresses that were identified and provided to the project author by the chief nursing officer staff. The survey was sent to 143 email addresses. A total of 23 surveys were completed, indicating a response rate of 16%. The majority (73.9%) of respondents that completed the survey were nurse administrators. Mean scores indicated that administrator respondents "moderately agreed" they understood the APN role and other nurse colleagues in their departments were supportive of the APN role; and "strongly agreed" they were supportive of the APN role. The results also indicated that administrators perceive barriers to APN practice in the following areas: scope of practice, physician colleague support and understanding of role, and APN job satisfaction in relationship to how APNs practice in their role. These potential barriers may keep the APN from practicing to their full scope of practice. Respondents indicated that if the APN was able to practice to their full scope of practice, patient outcomes may be improved. The information obtained by this project may help provide strategies to improve APN satisfaction, understanding of the APN role, reduced barriers to APN practice, and reduced APN job turnover.

Administrator Perceptions of Advanced Practice Nursing Barriers to Practice

## Chapter One: Nature of the Project

### Introduction

Advanced practice nurses (APNs) are an integral element in the healthcare team. APNs include: nurse practitioners (NPs), nurse midwives (NMs), certified registered nurse anesthetists (CRNAs), and clinical nurse specialists (CNSs). APNs practice in all entities of health care including: primary care, acute care, and specialty practices. CNP workforce is expected to continue to grow steadily through 2020 (Auerbach, 2011). In the last several years, APNs have doubled in number and now make up over 25% of healthcare providers at a large healthcare system in the Midwest. Improving APN retention may lead to improvement in patient care. If administrators have a thorough understanding of the APN role, APN job satisfaction may improve.

### Purpose

The purpose of this Doctorate of Nursing Practice (DNP) project was to identify the non-physician executive leaders' perceptions of barriers to APN practice at a large academic medical center in the Midwest. The leaders included business and nursing administrators and nurse managers. The administrators' and managers' perceptions were obtained by survey. The survey included questions related to the administrators' perceptions of APN job satisfaction, knowledge related to APN scope of practice, support and collaboration with physician colleagues, perception of APN role, support from administration, benefits, and billing.

## Project objective

The primary objective for this DNP project was to use a survey to gain an understanding of the non-physician executive leaders' perceptions of APN barriers to practice. The survey also determined the leader's knowledge of the APN role, scope of practice, and satisfaction.

## Significance of Project to Nursing and Healthcare

The Ohio State University Wexner Medical Center (OSUWMC) is an example of a large academic medical center in the Midwest. OSUWMC's strategic plan has several entities and includes both the goals of today, and the future. Ideas for this plan began in February of 2004, using the mission, vision, and values to formulate goals for each of the three mission areas; research, education, and patient care. From this, five focus areas were proposed to provide change and ensure success of the organization. These five areas include: financial, space, technology, people, and signature program (Onesource, 2011).

The purpose of this DNP project was related to the people focus. Due to the increasing need for APNs in every arena of health care, it is imperative to create a workplace of choice for APN providers. One of the strategic plan focus areas for OSUWMC addresses the following concept, "people are at the heart of our success, so strategies for recruitment and retention are a high priority. The people plan is designed to help the organization be a high-performance organization and a workplace of choice" (Onesource, 2011, About Our Strategic Plan, para. 4). APN satisfaction and retention rates may be affected by current issues surrounding the aforementioned topics included in the DNP project. The mission of the OSUWMC organization is "to improve people's lives through innovation in research, education and patient care" (Onesource, 2011, Mission, Vision, Values, para. 1). The core mission values include: integrity,

teamwork, innovation, excellence, and leadership. The vision of the organization is "working as a team, we will shape the future of medicine by creating, disseminating and applying new knowledge and by personalizing health care to meet the needs of each individual" (Onesource, 2011, Mission, Vision, Values, para. 2). OSUWMC strives for personalized health care due to the unique, individualized needs of each and every patient.

In 2001, the Institute of Medicine (IOM) in *Crossing the Quality Chasm: A New Health System for the 21st Century*, developed six areas of focus, representing the key areas in which health care can begin to be improved (IOM, 2001). These areas include: safety, effectiveness, efficiency, equitability, timeliness, and patient-centered care. The IOM goals strive for improvement in quality of care for each and every patient and their family. The goals of the IOM, in addition to the mission, vision, and values of OSUWMC, collectively support APN practice, as APNs play an integral role in improving quality of care.

The changes in health care created by the Affordable Care Act (ACA) will increase healthcare services to millions of Americans. APNs are key players in providing care to patients, especially in primary care and rural areas. The increased healthcare coverage for the previously uninsured and growing numbers in the aging population are expected to create a major shortage of healthcare providers. The shortage of PCPs is expected to reach up to 44,000 by 2025 and increase general medicine practice workload by 29% (Colwill, Cultice, & Kruse, 2008). Studies have shown APNs can deliver equal quality care when compared to physicians, and in some cases APNs have improved outcomes (Newhouse et al., 2011).

In 2010, the IOM submitted a report entitled *The Future of Nursing: Leading Change, Advancing Health* which described recommendations for the nursing profession. The IOM,

partnered with the Robert Wood Johnson Foundation (RWJF), released four main target areas for the nursing profession. These included: practicing to the highest potential of nursing education, increasing education for nurses, nurses becoming full partners with physicians and other members of the healthcare profession as part of the redesigning of the US healthcare system, and improving data collection and information infrastructure needed for workforce planning and policy making (Committee on the Robert Wood Johnson Foundation [RWJF], 2010). The target areas for improvement served as a basis for the development of recommendations for improvement measures. In a redesigned healthcare delivery system, it is important that healthcare administrators and managers have an understanding of APN practice. Therefore, assessing the perceptions of administrators and managers about APN barriers to practice, satisfaction, and role may continue to help bridge the practice gap between APNs and administrators.

**Definition of Terms**

Advanced Practice Nurse (APN): an umbrella term to describe a nurse with advanced education and training, which includes: nurse practitioners (NPs), nurse midwives (NMs), certified registered nurse anesthetists (CRNAs), and clinical nurse specialists (CNSs)

Certified registered nurse anesthetist (CRNA): an APN who provides care for surgical patients requiring pre-operative assessments, administration of anesthesia, and post-operative management

Clinical nurse specialist (CNS): an APN who provides consultation, research, education, administration, coordination of care, and case management services to a specific patient population

Certified nurse midwife (CNM): an APN who provides care to women for well-women gynecological care, management during pregnancy and childbirth, and antepartum and postpartum care

Nurse practitioner (NP): an APN who can provide a wide range of services to patients and population groups including: evaluation, diagnosis, treatment, education, coordination of care, and counseling

Privilege form: a requirement for APNs at an individual institution that includes specific procedures and privileges APNs can perform

Standard care arrangement (SCA): an agreement document between APNs and collaborating physicians that is mandatory in some states, including Ohio

## Chapter Two: Review of Literature

The purpose of this DNP project was to identify non-physician executive leaders' perceptions of barriers to APN practice at a large academic medical center in the Midwest. The project was a survey design. The survey was designed to identify the non-physician administrator's knowledge of key barriers of APN practice, including topics related to role and APN practice satisfaction. The setting included a general inpatient hospital, oncology, psychiatry, and cardiology specialty hospitals, and outpatient ambulatory care settings, where approximately 550 APNs were employed. Non-physician executive leaders including business and nursing administrators and managers made up the sample. Chapter two will focus on the literature review.

### Literature Review

The literature review addresses the administrators' perceptions of APN barriers to practice, satisfaction, role, and scope of practice. Literature sources included: CINAHL, Medline, and PubMed covering the last 20 years. The review of the literature included data from national, state, and local APN surveys. No specific articles were found pertaining to administrators' perceptions of APN barriers to practice or job satisfaction.

While no specific journal article regarding administrator's knowledge of APN satisfaction was identified, Cowden & Cummings (2011) addressed the managers' impact on nurses' intent to stay. In summary, Cowden & Cummings (2011) found that increased manager understanding of causal influences on nurses' intent to stay may result in increased retention rates. Kacel, Miller, & Norris (2005, p.27) described, "work experience is an integral part of an individual's identity. A person's profession is the principal activity that allows for fulfillment of

one's education, training, and abilities and provides the worker with a sense of competence and accomplishment." Kacel et al., (2005, p. 27) elaborated, "job satisfaction influences employee retention, decreased absenteeism, improves work productivity, and enhances performance. Therefore, an understanding of the factors that lead to job satisfaction is important to assist both employers and employees to improve the workplace."

Barriers to APN practice were examined in the literature. Clarin (2007) summarized 12 recent articles using the following key terms: nurse practitioner (NP), physician, and collaboration. The articles were published in the past 10 years, written in the English language, published worldwide, and included descriptive studies showing interprofessional relationships of NPs and physicians and stories of collaboration (Clarin, 2007). The barriers identified in the literature analysis included: decreased physician knowledge of scope and role of the APN, lack of respect, poor physician attitudes, poor communication, and patient and/or family reluctance to accept NP care. Cassidy (2012) in a policy brief also identified barriers to APN practice in regard to restrictions on scope of practice. Farley-Toombs, the President of the American Psychiatric Nurses Association (APNA) in 2011, described one of the primary issues surrounding APN barriers to practice as variances amongst states (Farley-Toombs, 2011). She stated, "this mixed array of rules and regulations leads to, in many instances, significant barriers for APRNs to move easily from state to state and reduces access to care for patients" (Farley-Toombs, 2011, p. 250). Since there is no federal law that would decrease scope of practice barriers of APNs, it is left to the individual states. Nineteen states have full practice authority. These include: Alaska, Arizona, Colorado, Hawaii, Idaho, Iowa, Maine, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, Vermont, Washington, and

Wyoming (Appendix A). The remainder of the states require some physician involvement in APN practice (Lowes, 2014).

Although no federal bill has been passed to decrease APN barriers to practice, one federal agency has commented on the issue. The Federal Trade Commission (FTC) suggests that limitations set on the state's ability to restrict scope of practice should be carefully considered (Federal Trade Commission [FTC], 2014). The FTC concluded that expanded APN scope of practice "should be a key component of our nation's strategy to deliver effective health care efficiently," and "is good for competition and American consumers" (FTC, 2014, p. 38).

> The FTC (2014, p. 38) also discussed barriers to practice for APNs including: mandatory physician supervision and collaborative practice agreement requirements are likely to impede competition among health care providers and restrict APRNs' ability to practice independently, leading to decreased access to healthcare services, higher healthcare costs, reduced quality of care, and less innovation in health care delivery. For these reasons, we suggest that state legislators view APN supervision requirements carefully.

The IOM further recommended that the FTC assess each state's scope of practice laws for any restricting unfair practices mandated by that state that would burden consumers (Gutchell, Idzik, & Lazear, 2014).

In response to the APN barriers to practice as variances amongst states, the APNA, the International Society of Psychiatric Nurses (ISPN), and the American Nurses Association (ANA) joined efforts and published the most recent edition of the *Psychiatric Mental Health Nursing Scope and Standards of Practice* in 2007. A consensus model was formed as a result of collaborative efforts among APN education, certification, and licensure bodies (Farley-Toombs,

2011). This model, known as the consensus model for APN Regulation: Licensure, Accreditation, Certification, and Education (LACE), has a goal to achieve clarity and unity in APN regulation and eradicate unnecessary barriers across all states, thus supporting full implementation of full scope of APN practice (Farley-Toombs, 2011). Licensure ensures the authority to practice; accreditation is the formal review process that takes place by the authorizing educational degree or certification program; certification is the formal evaluation of standards recognized by the profession; and, education is the formal preparation in the graduate degree-granting program (APRN Joint Dialogue Group Report, 2008). Representation on the LACE board includes: state licensing boards, accrediting organizations that accredit the four APN roles, APN certifying organizations, and educational organizations that set standards for APN education.

In a national study that was conducted by the American Academy of Nurse Practitioners (AANP), APN job satisfaction was examined. Data was collected from 254 NPs that attended the 2008 AANP annual conference (De Milt, Fitzpatrick, & McNulty, 2011). The goals of the study were to examine job satisfaction using the Misener NP Job Satisfaction Scale (MNPJSS), evaluate this based on their intent to leave their current position or role, and to describe this relationship between satisfaction and expected turnover in the profession. It was the first national study to evaluate these three areas. The results showed overall NPs were satisfied with benefits, challenge and autonomy, but minimally satisfied with professional growth, partnership within their practice, and collegiality. Twenty-seven percent of NPs were expected to leave their current role (De Milt et al., 2011). Of this 27% expected to leave their current role, 27.5% planned to leave within one to eleven months, 21.7% planned to leave within one year, 20.3%

planned to leave within one to two years, and 30.4% planned to leave in three to five years (De Milt et al., 2011).

Sample size was a limitation of the AANP study. The sample included only those that are members of AANP and also participated in the 2008 AANP conference. De Milt et al. (2011) suggested that those attending may actually be more satisfied with their jobs than those that do not attend such events. Therefore, expected turnover percentages may actually be higher. There was a significant inverse relationship between decreased job satisfaction and anticipated turnover, which directly affects patient quality of care by restricting autonomy and reducing APN control of outcomes (De Milt et al., 2011).

A national survey examining APN satisfaction was completed in 2011 at the Veterans Health Administration (VHA). Faris et al. (2011) found APNs overall to be minimally satisfied with their jobs. APNs at the VHA were most satisfied with benefits and least satisfied with professional growth and intrapractice collegiality. Faris et al. (2011) showed that CNSs were found to be more satisfied with their jobs than NPs. The following barriers identified by the researchers included: too many non-APN tasks, lack of administrative support, and inadequate time to do research (Faris et al., 2011).

A total of three studies examining APN satisfaction in individual states were identified in this literature review. A study conducted in Maine of NPs and CNMs by Keith, Coburn, & Mahoney (1998) addressed similar issues to the Faris et al. (2011) study. Keith et al. (1998) included satisfaction and additional questions related to the APNs' perceptions of physician supervision and scope of practice. Half of the respondents stated their scope was inappropriately limited by physician supervision and reimbursement. The respondents were dissatisfied with the

position benefit aspects. Satisfaction was the highest for professional practice issues, such as quality of care given to patients when working with the physician, location of practice, number of patients in the community, and available physician coverage (Keith et al., 1998). Since this study was conducted, Maine is now one of the states with full practice authority.

A study of APN satisfaction was conducted by Kacel et al. (2005) in a Midwestern state. The state was not identified. There were 147 completed self-administered questionnaires that included 44 items. The items included a six point Likert-type scale with responses ranging from "very satisfied" to "very dissatisfied." Kacel et al. (2005) found that "least satisfied" categories included: time off for professional committees, reward distribution, research involvement, compensation outside of normal work duties, monetary bonuses, and salary. According to Kacel et al. (2005), satisfaction fell steadily with each additional year of APN experience, with the first year of practice as the most satisfied. There was a plateau of dissatisfaction scores at eight to eleven years of practice.

A study, conducted by Dunaway & Running (2009), included a NP job satisfaction survey in the state of Nevada. In Nevada, there is significant population growth and subsequent healthcare provider shortage. Until the Dunaway & Running (2009) study was published for Nevada, there was no NP job satisfaction information available in this state. Five hundred and twelve surveys were mailed to NPs (Dunaway & Running, 2009). There were a total of 315 participants. The results of NP job satisfaction varied between "very satisfied" to "dissatisfied." The results of the Nevada study indicated that the overall satisfaction rate of NPs was "minimally satisfied" to "satisfied." The NPs felt positive about their work and how they did it; however, they were more dissatisfied with the professional growth opportunities and collegial and monetary benefits that they expected to receive (Dunaway & Running, 2009). This Nevada

study data correlated with the other studies examined in this literature review, which may assist healthcare leaders and upper level management with ways to improve NP job satisfaction. The Nevada study findings may be used to help maximize the role for improving patient access to care, particularly in states such as Nevada, with a growing population and shortages of providers. Dunaway & Running (2009) recommended satisfaction research as being essential to understanding the factors that influence the NP role and success in modern healthcare systems. The Nevada study findings directly relate the IOM goals of improving equitability among patient groups and also patient access to care. Since this study was conducted, Nevada became a state with full practice authority in 2013.

Currently APN practice is governed by the individual states; therefore, it is important to measure satisfaction and role perception on a statewide level. There are no known reports of role perception or satisfaction in Ohio at the time of this literature review. The latest available data from a local source includes a 2009 NP survey at OSUWMC. A more recent survey in April 2013 was conducted; however, the results were unavailable at the time of this literature review.

The NP satisfaction survey results from May 2009 at OSUWMC were reviewed. There were a total of 59 NP responses; the majority of respondents had masters' degrees and a few had doctorates. The majority of respondents had 0-5 year experience as a NP. The topics that were addressed included: credentialing process, orientation process, quality monitoring, evidence-based practice, Magnet process, computer based learning, Advanced Practice Nursing Communications (APNC) tool and website, continued education, annual evaluations, research ability, speaking engagements and mentorships, reimbursement/billing, NP role recognition, legislation and The Ohio Board of Nursing, satisfaction level in current position, opportunity to network with other NPs, and ability to communicate concerns to the Chief Nursing Officers and

upper level management. The responses to the survey questions included: "very dissatisfied," "somewhat dissatisfied," "neither satisfied or dissatisfied," "somewhat satisfied," and "very satisfied." In no one area did "very satisfied" get the majority of responses. The results varied between "very dissatisfied" and "somewhat satisfied" categories. The following topics had majority percentages in the "very dissatisfied" or "somewhat dissatisfied" categories: credentialing, quality monitoring, yearly evaluations, and reimbursement and billing (Onesource, 2009). The following topics had majority percentages in the "somewhat satisfied" category: orientation, incorporating evidence-based practice into role, APN website, and continuing education (Onesource, 2009).

Another measure identified in the literature that addressed staff satisfaction, including APN staff is the Hospital Consumer Assessment of Healthcare Providers and Systems surveys (HCAHPS). As of 2013, HCAHPS scores were one of the measures that the Center for Medicare and Medicaid Services (CMS) used for the new Hospital Value-Based Purchasing Program (Bush, 2011). The HCAHPS questionnaire included 18 core questions regarding the patient's hospital experience. Some hospitals are using the "trickle down" approach to improve these scores, starting with staff satisfaction, which then impacts patient satisfaction. Bush (2011) described the history of health care regarding employee satisfaction as undervalued and a needed area of change. Bush (2011) suggested that undervaluing employee satisfaction impacts patient satisfaction scores. HCAHPS relates to the IOM quality in the effectiveness category, in addition to patient-centered care. Staff satisfaction was further summarized by Bush (2011, p. 24):

> Heightened employee morale and engagement can reap dividends beyond harnessing employee goodwill and passing it on to patients. Frontline staffers have a realm of

expertise about the day-to-day life of a hospital that's hard to find elsewhere. If staff feel engaged and respected, they are more likely to share their observations on patient care.

Improved HCAHPS scores, patient centered outcomes, and increased effectiveness and efficiency coincide with increased staff satisfaction (Bush, 2011).

The impetus of collecting APN survey data is related to understanding the satisfaction and role of the APN. If there is a lack of understanding of the APN role, this may present challenging issues. A lack of understanding of the APN role directly relates to underutilization of the APN and role conflict amongst colleagues (Bryant-Lukosius, DiCenso, Browne, & Pinelli, 2004; Clarin, 2007). Some examples of lack of knowledge regarding the APN role include: APNs being employed to solve a particular healthcare problem instead of the need for the APN role being the reason for hire, variable APN role interpretations based on varied expectations of non-nursing managers or physicians, and role confusion related to inexperience with the APN role (Bryant-Lukosius et al., 2004).

It is important to assess the non-physician executive leaders including business and nursing administrators' and managers' perceptions of APN potential barriers to practice, satisfaction, and role at various institutions. To date, no studies were conducted that have addressed the perception of administrators in regard to APN issues. Due to the increasing rate of APN employment, it was important to assess the views of the administrators to help obtain cohesiveness amongst colleagues, which may ultimately improve patient care. It was important to assess types of practices due to the inconsistencies at individual sites. For example, at the time of this study at OSUWMC there was no reporting structure for APNs on a system-wide level. The reporting structure for APNs varies per department within the medical center.

Therefore, gaining an understanding of administrator's knowledge of APN barriers to practice, job satisfaction, and role may result in the development of an organizational structure for APNs, which may then improve APN satisfaction.

# Chapter Three: Methodology

## Project Design

The purpose of this DNP project was to identify the non-physician executive leaders' perceptions of key barriers for APN practice at a large academic medical center in the Midwest. The project was a survey design. The survey was designed to identify the administrator's knowledge of APN barriers to practice, satisfaction, and role of APN practice. The administrator survey was adapted from a recent 2013 APN survey. The setting included a general inpatient hospital, oncology, psychiatry, and cardiology specialty hospitals, and outpatient ambulatory care settings, where approximately 550 APNs were employed. Non-physician executive leaders, business and nursing administrators, and nurse managers were included in the sample. There were 143 total administrators, and over 100 of these were nurse managers. The project was submitted to the Behavioral and Social Sciences Institutional Review Board (IRB) for an expedited review and was approved on February 11, 2014 (Appendix B). Data collection began on March 4, 2014 after approval from the IRB and was completed on March 18, 2014.

## Sample

The author used an online survey of non-physician executive leaders including business and nursing administrators and managers to assess perceptions of APN barriers to practice, satisfaction, and role. All administrators were current employees of a large academic medical center in the Midwest. There were no exclusion criteria. The survey was provided in an emailed link to the respondents. The recipients were first asked to identify whether they currently work with an APN, and if so, to continue the survey. If the administrator did not work with an APN, they were asked to select "no" and exit the survey.

## Instruments

The survey was designed to identify the administrator's knowledge of key barriers of APN practice, satisfaction, and role. The administrator survey was adapted from a recent APN survey from April 2013. The instrument used in this project included self-report measures which were collected from the online surveys. The questions were reformatted to capture the administrator perspective. The purpose of the survey was to assess knowledge of the non-physician executive leaders including business and nursing administrators and managers. In this survey (Appendix C) there were a total of 77 questions, including demographic information. These items included pertinent issues related to APN billing, benefits, autonomy, practice restrictions, and professional development. Validity and reliability for the instrument was not tested.

## Methods

A survey that was used for APN satisfaction was adapted by the author to capture the administrator's perception of key barriers for APN practice, satisfaction, and role of the APN. Data collection procedures included completions of the surveys. The responses from administrators included several Likert scales, choice completions, and narrative comments, using Checkbox, an online survey tool. The Likert scale for the barriers section included the following options: "strongly agree," "moderately agree," "slightly agree," "neither agree nor disagree," "slightly disagree," "moderately disagree," "strongly disagree," and "unknown." The Likert scale pertaining to the satisfaction questions included the following options: "very satisfied," "satisfied," "minimally satisfied," "minimally dissatisfied," "dissatisfied," and "very dissatisfied." The survey can be found in Appendix C. The list of participants was obtained

through meeting with a Chief Nursing Officer, a representative from the Chief Nurse Executive's office, and with the assistance of a nurse manager. The same survey questions were distributed to all of the administrators via their medical center email. There was a reminder email sent seven days prior to the closing of the survey.

Barriers to this method of surveying included: response rate related to the surveys in regard to participation, non-response to certain questions or items, and concerns with recall. The surveys were anonymous to increase response rate.

**Data Analysis Plan**

This project design was a descriptive survey. Descriptive analysis statistics were used for variables to determine pattern of mean scores with standard deviations and frequency distribution. Narrative questions were summarized. A statistician at The Ohio State University College of Nursing assisted in data analysis. The analysis included monitoring for trends. Data was kept in a locked storage compartment for privacy purposes.

# Chapter Four: Findings

## Results

The purpose of this DNP project was to identify the non-physician executive leaders' perceptions of key barriers for APN practice at a large academic medical center in the Midwest. A total of 143 email addresses were collected from nursing administration. A total of 23 surveys were completed, indicating a response rate of 16%. Of these 23 surveys, 17 respondents were nurses and four were not. There were two respondents that did not answer the question related to whether they were a nurse or not a nurse. There were eight respondents who logged in to the survey and selected "no," they do not work with APNs. This number was not included in the response rate. The average length of time the respondents have been in a management or administrative role was 10.2 years. The average length of time the respondents have worked with APNs at this particular place of employment is 7.65 years. The survey results are noted in table format in Appendix D and E. A more complete discussion of the results follows.

The survey included questions on the following topics: barriers to APN practice, scope of practice, standard care arrangement (SCA), privilege form, APN role and support of this role, APN satisfaction, benefits, billing, orientation, reporting structure, annual evaluations, time allotted for job responsibilities, work environment, and professional growth. The survey questions are listed in Appendix C. The first 47 questions were grouped into the following categories for summary statistical purposes: barriers, remuneration, time allotted for job responsibilities, working with others, work environment, and professional growth. For the respondent to be included in the sample for each group, half of the items in that group had to be answered. There was one item in the barriers section that was reverse coded; the remainder of all

of the items were coded by averaging each of the subject's responses within that question group (Table 1). The eight-point Likert scale of the barriers section included "strongly disagree" recorded as "1," "moderately disagree" recorded as "2," "slightly disagree" recorded as "3," "neither agree nor disagree" recorded as "4," "slightly agree" recorded as "5," "moderately agree" recorded as "6," "strongly agree" recorded as "7," and "unknown," which was recorded as "8." The barriers section mean score was 5.42 indicating that the respondents responses ranged from "slightly agreed" to "moderately agreed" to the questions addressed in barriers section.

Each question in the barriers section was individually analyzed. Respondents "neither agreed nor disagreed" that APNs in their given department were currently able to practice to their full scope of practice allowable by the Ohio law. Respondents "slightly agreed" that the physician colleagues in their department were supportive of the APN role; and, "neither agreed nor disagreed" that the physician colleagues understood the APN role. Within the "moderately agreed" category, respondents believed the following: they understood the APN role, the APN's job satisfaction was related to how the APN practices in their current role, and they believed the nurse colleagues in their department were supportive of the APN role. Respondents also "moderately agreed" that they were supportive of the APN role themselves, and that if the APNs were allowed to take on more responsibility under their scope of practice, patient outcomes may be improved. Respondents selected a mean of "moderately agree" to the question addressing multiple barriers in which the APNs practice environment keeps them from practicing to their full scope of practice.

Respondents were allowed to free text responses related to the least satisfying aspects of APNs in their departments and to the biggest barriers related to improved satisfaction of the

APNs in their departments. The following were summary categories in which respondents answered in response to the free text questions pertaining to barriers: physician and administration barriers, lack of team culture ("this is a physician hospital" and "lack of team thinking"), reporting structure, lack of independence, lack of role definition, and inability to practice to the full scope of practice.

The next five categories, including remuneration, time allotted for job responsibilities, working with others, work environment, and professional growth were grouped using a six-point Likert scale. The Likert scale consisted of the following options: "very satisfied" which correlated to "6," "satisfied" which correlated to "5," "minimally satisfied" which correlated to "4," "minimally dissatisfied" which correlated to "3," "dissatisfied" which correlated to "2," "very dissatisfied" which correlated to "1," and "unknown," which correlated to "0." The following mean results were found in regard to perceived APN satisfaction: remuneration (4.32 = minimally satisfied), time allotted for job responsibilities (4.49 = minimally satisfied/satisfied), working with others (4.35 = minimally satisfied), work environment (4.46 = minimally satisfied/satisfied), professional growth (3.94 = minimally satisfied/minimally dissatisfied).

Respondents were allowed to free text comments related to the satisfaction questions in the survey. The following were summary categories in which respondents answered in response to the free text questions pertaining to satisfaction: autonomy with patient care and practice, flexibility, compensation (not being competitive, decreased salaries compared to other healthcare systems), and lack of conference funding.

Twenty-one items were statistically analyzed by frequency distribution (Appendix E). The majority (80.9%) of the respondents reported they work with either NPs or CNSs and are in

nursing administration positions (77.8%). The majority of respondents (70%) were familiar with the required SCA and felt it was helpful to their APN's practice; however, 25% reported they were unfamiliar with SCA. In addition to the SCA, APNs at this health system are required to complete a privilege form that specifically addresses allowable procedures the APN may perform. The majority (55%) of respondents were unfamiliar with the required privilege form. The survey addressed APN time spent with patients in regard to satisfaction. Sixty-one percent of the respondents thought APNs were satisfied with the time they are able to spend with patients.

APNs are allowed by law to independently bill for their services. Other billing options included: not billing, shared billing with the physician, "incident-to" the physician, and procedure billing only. The shared billing option is when both the APN and the physician see the patient during the visit; whereas, the "incident-to" billing option is when the APN sees the patient and bills under the physician's information. With the "incident-to" billing option, the physician has to be present in the office suite and available for immediate consultation, the APN cannot address any new complaints, and the APN cannot see new patients. The survey respondents reported that 66.7% of the APNs in their department do not bill, followed by 18.75% that bill both shared visits with the physician and also independently. Twenty-five percent of the respondents reported billing by the APN either "incident-to" the physician or both "incident-to" the physician and independently. Only 6.25% of the respondents reported that the APN bills independently.

The survey respondents were asked to identify how APNs in their department were hired and which employer group provides benefits to the APN. The majority of APNs (38.1%) were hired by the university, followed by 33.3% being split by the university and a university

physicians group, and 23.8% where the respondents reported unknown. Benefits were provided by the university at 61.9%, followed by split by the university and a university physicians group at 23.81%. For those APNs that were split employment and benefits by the university and a university physicians group, 26.32% of the respondents reported they were aware of the differences between the university and the university physicians group benefits; however, 21.05% were not.

The survey respondents were questioned about the completion of the APN annual evaluations and reporting structure. Annual evaluations for APNs were completed by nursing personnel in 75% of the responses, followed by 12.5% by physicians, and 6.25% by a non-clinician administrator. The reporting structure varied amongst the health system. The respondents reported the majority of APNs (71.43%) did not report to them as an administrator, followed by 28.57% of the APNs that did report to them. If the APN did not report to the administrator completing the survey, they were asked to report to whom the APN reported. The majority of APNs (46.67%) who did not report to the administrator completing the survey, reported to an APN, followed by 13.33% to a non-clinician administrator. Eighty percent of respondents reported that they believed there were concerns about current APN structure. Free text comments regarding reporting structure of APNs included that it was "disjointed," "should standardize," and that "APNs should report to a leader who has a similar education level."

**Discussion**

Mean scores indicated that administrator respondents "moderately agreed" they understood the APN role and other nurse colleagues in their departments were supportive of the APN role; and "strongly agreed" they were supportive of the APN role. The results also

indicated that there may be barriers identified from an administrator perspective in regard to APN practice in the following areas: scope of practice, physician colleague support and understanding of role, APN job satisfaction in relationship to how APNs practice in their role, and possible barriers which keeps the APN from practicing to their full scope of practice. The respondents indicated that they believed if the APN was able to practice to their full scope of practice, patient outcomes may be further improved.

Administrator perceptions of APN satisfaction in regard to remuneration, time allotted for job responsibilities, working with others, work environment, and professional growth indicated a mean of being "minimally satisfied" in all groups, with professional growth being the lowest mean score. These issues of APN satisfaction may be used to identify areas for improvement.

Reported areas of concern within the frequency distribution involve the following areas of APN practice: SCA, privilege form, billing, annual evaluations, and reporting structure. These areas of concern may represent a starting point for working towards a more cohesive model regarding APN practice.

**Conclusions**

The survey respondents identified some initial areas of concern surrounding APN satisfaction, role, and barriers to practice. These initial areas include: scope of practice, physician colleague support and understanding of role, APN job satisfaction in relationship to how APNs practice in their role, and possible barriers which keeps the APN from practicing to their full scope of practice. Additionally, areas of APN satisfaction were reported as mean scores of being "minimally satisfied" in areas including: remuneration, time allotted for job responsibilities, working with others, work environment, and professional growth. These target

categories may represent areas for improvement within the health system. Lack of professional growth opportunities has been a consistent finding amongst previous studies (De Milt et al., 2011; Faris et al., 2011).

Results of this survey may help administrators gain an understanding regarding APN satisfaction, role, and barriers to practice. The results may also help to provide an organizational starting point for areas identified for improvement. The survey answers help to delineate areas in which respondents felt positive towards the APN profession, such as the respondents understood the APN role, were supportive of it, and reported that other nurse colleagues in their departments were supportive of the role. The results also indicated that the respondents believed if the APN is able to practice to their full scope of practice, patient outcomes may be further improved. Knowing both positive and negative aspects of the administrators' perceptions of APN satisfaction, role, and barriers to practice may help provide areas of focus for improvement strategies, which ultimately may lead to increased satisfaction, better understanding of APN role, reduced barriers to APN practice, and reduced turnover amongst the APNs employed at this health system.

# Chapter Five: Summary

## Study Summary

The purpose of this DNP project was to identify the non-physician executive leaders' perceptions of key barriers for APN practice at a large academic medical center in the Midwest. This information was obtained by a 77-item survey that was administered to 143 non-physician executive leaders. The response rate was 16%. The majority of administrator respondents believed that they understood the APN role, were supportive of it, and that other nurse colleagues in their departments were supportive of the APN role. The results also indicated that the administrators acknowledged barriers related to APN practice in the following areas: scope of practice, physician colleague support and understanding of the APN role, APN job satisfaction in relationship to how APNs practice in their role, and possible barriers which keeps the APN from practicing to their full scope of practice. The results further indicated that the administrators think if the APN is able to practice to their full scope of practice, patient outcomes may be improved. The information obtained by this DNP project may help provide areas of focus for improvement strategies for APN practice, which ultimately may lead to increased satisfaction, better understanding of the APN role, reduced barriers to APN practice, and reduced turnover of APNs within this health system.

## Limitations

Response bias existed with a survey methodology. Due to the survey length, the instrumentation possibly introduced limitations. The sample size is small for the amount of potential participants. Validity and variability for the instrument was not tested.

**Implications for Nursing Practice and to the DNP Essentials**

The implications for advanced nursing practice relative to these DNP project findings as it relates to the DNP essentials are described below. There are eight essentials in the DNP education (American Association of Colleges of Nursing [AACN], 2006). These include:

I. Scientific Underpinnings for Practice

II. Organizational and Systems Leadership for Quality Improvement and Systems Thinking

III. Clinical Scholarship and Analytical Methods for Evidence-Based Practice

IV. Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care

V. Healthcare Policy for Advocacy in Health Care

VI. Interprofessional Collaboration for Improving Patient and Population Health Outcomes

VII. Clinical Prevention and Population Health for Improving the Nation's Health

VIII. Advanced Nursing Practice

This DNP project specifically addresses four of these DNP essentials.

**Essential II: organizational and systems leadership for quality improvement and systems thinking.** This project addressed both institutional, within this particular health system, and policy arenas. There is an intricate balance between practice management, productivity, and quality of care. The project results specifically identified areas for improvement in the reporting structure at this health system. The results further indicated that administrators felt if the APN was able to practice to their full scope of practice, patient outcomes may be improved. The dynamic nature of institutional policies and procedures correlates with potential APN barriers to practice on many levels. Practice improvements require changes in organizational and institutional culture and can be a vital role for the DNP (AACN, 2006).

**Essential V: healthcare policy for advocacy in health care.** Policy at all levels in health care creates a working structure that can facilitate or impede the delivery of health care services (AACN, 2006). Healthcare policy impacts the provider's ability to be involved in a practice that can assess healthcare needs. Professional nursing practice, and specifically the DNP, plays a direct role in policy assessment, development, leadership, and change when needed. APN barriers are occurring at national, state, and institutional levels which can strongly influence nursing practice. This project specifically identifies potential barriers to practice in which policy changes may be warranted. These include: scope of practice, physician colleague support and understanding of role, APN job satisfaction in relationship to how APNs practice in their role, and possible barriers which keeps the APN from practicing to their full scope of practice.

**Essential VI: interprofessional collaboration for improving patient and population health outcomes.** With today's changes in healthcare systems, it is crucial that multiple professions work together to provide the best health care possible to improve patient outcomes. This DNP essential applies to nursing practice in conjunction with the IOM six focus areas. Healthcare professionals must work in a collaborative environment. The significance of this project relates to interprofessional collaboration by gaining an understanding of the administrator's knowledge of APN job satisfaction, role, and barriers to APN practice, which may result in the development of alleviating factors to overcome the issues assessed.

**Essential VIII: advanced nursing practice.** In summary, this DNP project supported advanced nursing practice as a DNP core essential and represented nursing practice from a global perspective. Part of APN practice includes working with other healthcare professionals to improve patient care and outcomes, participating in advanced levels of systems-based thinking,

guiding, mentoring, and supporting fellow nurses, and using conceptual and analytical skills in assessing practice, organizational, population, fiscal, and policy arenas (AACN, 2006). The impetus of this DNP project surrounds these underlying implications for nursing practice and the DNP essential of advanced nursing practice.

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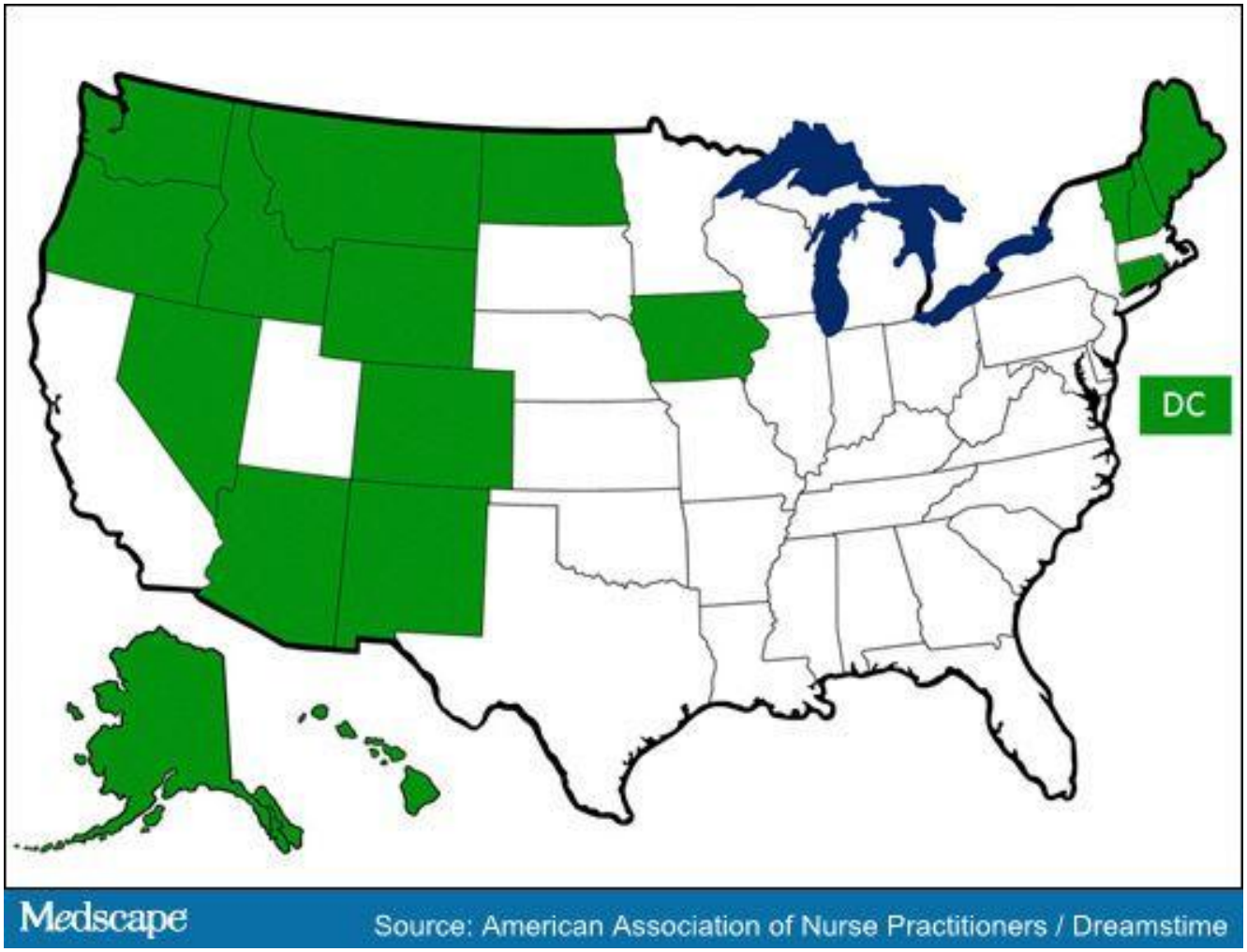
Appendix A




- No physician involvement needed to diagnose, treat, or prescribe

- Source: Lowes, R. (2014). Connecticut becomes 18th state to allow NP independence. *Medscape*. Retrieved from www.medscape.com

Appendix B

## 1. PROJECT TITLE

**Administrator Perceptions of Advanced Practice Nursing (APN) Barriers to Practice**

## 2. INSTITUTIONAL REVIEW BOARD

Select the Board to review this research:

***Final Board assignment is determined by ORRP.***

X Behavioral and Social Sciences

☐ Biomedical Sciences

☐ Cancer

## 3. PRINCIPAL INVESTIGATOR (or Advisor) – see Qualifications for service as a PI

Name (Last, First, MI):
Graham, Margaret

Degree(s):
Ph.D, FNP, PNP

University Academic Title:
Associate Professor

College (TIU):
Nursing

Department Name (TIU):
Nursing

Department # (TIU):
17000

Campus Mailing Address:
136 Newton Hall
1585 Neil Avenue
Columbus, OH 43210

University ID Number:
07176527

E-mail:
Graham.548@osu.edu

Fax: 614-292-4948

Phone: 614-688-4984

Emergency phone: 614-230-7465

## 4. CO-INVESTIGATOR(S)

Are there any Ohio State University co-investigators on this protocol?

**X** Yes → Complete **Appendix A1**

No

***Signatures of co-investigator(s) are required on Appendix A1.***

## 5. KEY PERSONNEL

Are there any Ohio State University key personnel on this protocol?

Yes → Complete **Appendix A1**

**X** No

***Key personnel are defined as individuals who participate in the design, conduct, or reporting of human subjects research. At a minimum, include individuals who recruit participants, obtain consent, or who collect study data.***

**Additional key personnel will be added as they are identified.**

## 6. EXTERNAL CO-INVESTIGATOR(S) & KEY PERSONNEL

Are any external (non-Ohio State University) investigators or key personnel *engaged* in the Ohio State research?

☐ Yes

**X** No → Go to Question #7

***"Engaged" individuals are those who intervene or interact with participants in the context of the research or who will obtain individually identifiable private information for research funded, supervised, or coordinated by Ohio State University. See OHRP Engagement Guidance or contact ORRP for more information.***

**If Yes** → Who will provide approval for these external personnel?

☐ Ohio State University IRB → Complete **Appendix A2**

☐ Non-Ohio State University IRB → ***Provide a copy of the approval(s)***

## 7. ADDITIONAL CONTACT(S)

If further information about this application is needed, specify the contact person(s) if other than the PI (e.g., study or regulatory coordinator, research assistant, etc.). ☐ **N/A**

| | |
|---|---|
| Name (Last, First, MI): Linder, Shannon, L. | Phone: **Cell 614-286-0773 or work 614-293-4969** |
| E-mail: Linder.53@osu.edu | Fax: **614-293-6111** |
| Name (Last, First, MI): | Phone: |
| E-mail: | Fax: |

***All Ohio State University individuals listed on this protocol will have access to information about IRB actions and the completion status of each individual's administrative and training requirements (CITI, COI disclosure). Personal financial information provided in COI disclosures is not included.***

## 8. EDUCATION

***Educational requirements (initial and continuing) must be satisfied prior to submitting the application for IRB review. See Human Subjects Protection Training or contact ORRP for more information.***

Have all Ohio State University investigators and key personnel completed the required web-based course (CITI) in the protection of human research subjects?

X Yes
☐ No

## 9. FINANCIAL CONFLICT OF INTEREST

***All Ohio State University investigators and key personnel must have a current COI disclosure (updated as necessary for the proposed research) before IRB review. Examples of financial interests that must be disclosed include (but are not limited to) consulting fees or honoraria; stocks, stock options or other ownership interests; and patents, copyrights and royalties from such rights. For more information, see Office of Research Compliance COI Overview and eCOI.***

a. Have all Ohio State University investigators and key personnel completed the required COI disclosure?

X Yes
☐ No

b. Does any Ohio State University investigator (including principal or co-investigator), key personnel, or their immediate family members have a financial interest (including salary or other payments for services, equity interests, or intellectual property rights) that would reasonably appear to be affected by the research, or a financial interest in any entity whose financial interest would reasonably appear to be affected by the research?

☐ Yes
X No

## 10. FUNDING OR OTHER SUPPORT

***If the research is federally funded and involves a subcontract to or from another entity, an IRB Authorization Agreement may be required. Contact ORRP for more information.***

a. Is the research funded or has funding been requested?

☐ Yes
X No

**If Yes** → Specify sponsor: _____

***Provide a copy of the grant application or funding proposal. The university is required to verify that all funding proposals and grants (new or renewals) have been reviewed by the IRB before funds are awarded.***

b. Is any support other than monetary (e.g., drugs, equipment, etc.) being provided for the study?

☐ Yes
X No

**If Yes** → Specify support and provider: _____

## 11. OTHER INSTITUTIONAL APPROVALS

Check all that apply and provide applicable documentation. ***See websites listed below for information on obtaining approvals. IRB review cannot be conducted until required institutional approvals or exemptions are obtained, except as noted.***

X **None**

☐ Clinical Research Center (CRC) Scientific Advisory Committee (SAC) – Approval required for research sponsored by the CRC. Final IRB approval will be held pending receipt of SAC approval.

☐ Institutional Biosafety Committee (IBC) – Approval required for research involving biohazards (recombinant DNA, infectious or select agents, toxins), gene transfer, or xenotransplantation.

☐ Comprehensive Cancer Center (CCC) Clinical Scientific Review Committee (CSRC) – Approval or exemption required for cancer-related research.

☐ Maternal-Fetal Welfare Committee – Approval required for some research involving pregnant women and fetuses.

☐ Human Subject Radiation Committee (HSRC) – Approval required for research involving radiologic procedures for research purposes (e.g., non-clinical care X-rays, DEXA or CT scans, nuclear medicine procedures, etc.).

## 12. LOCATION OF THE RESEARCH

***Research to be conducted at locations other than approved performance sites will minimally require a letter of support and may require another IRB's approval if personnel are engaged. See OHRP Engagement Guidance or contact ORRP for more information.***

a. List the specific site(s) at which the Ohio State research will be conducted (include both domestic and international locations).

| Location Name (or description) | Address (street, city and state, or country) |
|---|---|
| **The Ohio State University Wexner Medical Center and the James Cancer Hospital** | **410 W. 10th Ave. Columbus Ohio 43210** |
| **University Hospital East** | **1492 E. Broad Street Columbus Ohio 43205** |
| | |
| | |

b. Are all the sites named above on the Ohio State list of approved research performance sites?

X Yes

☐ No

**If No →** ☐ Domestic sites → ***Provide a letter of support, as applicable***

☐ International sites → Complete **Appendix U**

c. Is the Ohio State PI the lead investigator or is The Ohio State University the lead site for collaborative research?

Yes

☐ No → Go to **Question #13**

X Not collaborative research →Go to **Question #13**

i. Describe the communication between sites that might be relevant to the protection of participants, such as unanticipated problems, interim results, and protocol modifications.

ii. Describe IRB oversight arrangements for each collaborative site (i.e., who will provide IRB review and approval). ***Provide copies of the non-Ohio State approvals, as applicable. Contact ORRP if requesting that Ohio State University serve as the IRB of record.***

## 13. EXPEDITED REVIEW

Are you requesting **Expedited Review**?

**X** Yes → Complete **Appendix B**

☐ No

## 14. SUMMARY OF THE RESEARCH

Summarize the proposed research using ***non-technical*** language that can be readily understood by someone outside the discipline. Explain briefly the research design, procedures to be used, risks and anticipated benefits, and the importance of the knowledge that may reasonably be expected to result. ***Use complete sentences (limit 300 words).***

The purpose of this project is to identify the administrator's perceptions of APN barriers to practice at a large academic medical center in the Midwest. The project design is an observational quantitative analysis of surveys of administrators. The survey is designed to identify the administrator's knowledge of key barriers of APN practice, role, perception of satisfaction, and scope of practice. The setting is The Ohio State University Wexner Medical Center and Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, where approximately 550 APNs are employed. Department and executive administrators will be included in the sample, including both business and nursing managers. Statistics will be used to determine central tendency and dispersion, normality of distribution, pattern of mean scores, and magnitude of the relationships among study variables. Qualitative analysis software will be used for the narrative questions.

Administrator participation is voluntary and anonymous, and will be delivered via employee email. There are no associated risks of taking the survey, other than time commitment and sharing of demographic information. It is important to assess the perceptions of the administration in regard to the APN barriers to practice at various institutions. To date, no studies have been conducted that have addressed the perceptions of administration in regard to these APN issues. Due to the increasing rate of employing APNs at large academic medical centers, it is important to assess the views of the administration to help obtain cohesiveness amongst colleagues, which will ultimately continue to improve patient care. It is important to assess types of practices due to the inconsistencies at individual sites. Currently at OSUWMC there is no reporting structure for APNs on a system-wide level. The reporting structure varies per

department within the medical center; therefore, understanding of administrator's knowledge of the APN barriers to practice may result in the development of an organizational structure for APNs, which may improve APN satisfaction.

## 15. SCIENTIFIC BACKGROUND & LITERATURE REVIEW

Summarize existing knowledge and previous work that support the expectation of obtaining useful results without undue risk to human subjects. ***Use complete sentences (limit 300 words).***

The focus of the proposal and the relationship with improved quality is examined due to the impact the administrator's knowledge of APN barriers to practice, satisfaction and role may have on APN satisfaction. To date, no studies have been conducted that have addressed the perception of administrators in regard to these APN issues. Due to the increasing rate of employing APNs at large academic medical centers, it is important to assess the views of the administrators to help obtain cohesiveness amongst colleagues, which will ultimately continue to improve patient care. It is important to assess types of practices due to the inconsistencies at individual sites. For example, currently at The Ohio State University Wexner Medical Center there is no reporting structure for APNs on a system-wide level, which varies per department. APN reporting structure, amongst issues aforementioned related to role and satisfaction within an institution may cause potential barriers for the APN role. Therefore, gaining an understanding of administrator's knowledge of the APN job satisfaction and role may result in the development of an organizational structure for APNs, which may then improve APN satisfaction.

While no specific articles were found regarding administrator's knowledge of APN, in a systematic review Cowden & Cummings (2011) described managers' impact on nurses' intent to stay in their current position. In summary, they found that increased understanding of causal influences on nurses' intent to stay may result in increased retention rates. Two national satisfaction surveys reviewed with APNs demonstrated overall minimal satisfaction with their jobs, more specifically with professional growth, partnership within their practice, and collegiality (De Milt, Fitzpartrick, & McNulty, 2011; Faris et al., 2011). Satisfaction studies conducted at the state level in three separate studies were reviewed and reported inappropriate restrictions on practice, decreased satisfaction, and need for improvement (Dunaway & Running, 2009; Kacel et al., 2005; Keith et al., 1998).

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## 16. RESEARCH OBJECTIVES

List the specific scientific or scholarly aims of the research study.

- To assess the administrator's perception of APN barriers to practice and satisfaction
- To assess the administrator's knowledge of the APN role and scope of practice

## 17. RESEARCH METHODS & ACTIVITIES

a. Identify and describe all interventions and interactions that are to be performed solely for the research study. Distinguish research (i.e., experimental) activities from non-research activities. ***Provide description (e.g., spreadsheet or forms) of data being collected. Do not include case report forms for multi-site industry-sponsored or cooperative group studies.***

The survey is attached. The survey will be conducted via OSUMC email via an online survey, using checkbox and free text.

b. Check all research activities that apply:

- ☐ Anesthesia (general or local) or sedation
- ☐ Audio, video, digital, or image recordings
- ☐ Biohazards (e.g., rDNA, infectious agents, select agents, toxins)
- ☐ Biological sampling (other than blood)
- ☐ Blood drawing
- ☐ Coordinating Center
- ☐ Data, not publicly available
- ☐ Data, publicly available
- ☐ Data repositories → Complete **Appendix C** (future unspecified use, including research databases)
- ☐ Deception → Complete **Appendix D** & **Appendix M1**
- ☐ Devices → Complete **Appendix E**
- ☐ Diet, exercise, or sleep modifications
- ☐ Drugs or biologics → Complete **Appendix F**
- ☐ Emergency research
- ☐ Focus groups
- ☐ Food supplements
- ☐ Gene transfer
- ☐ Genetic testing → Complete **Appendix G**
- ☐ Internet or e-mail data collection
- ☐ Magnetic Resonance Imaging (MRI)
- ☐ Materials that may be considered sensitive, offensive, threatening, or degrading
- ☐ Non-invasive medical procedures (e.g., EKG, Doppler)
- ☐ Observation of participants (including field notes)
- ☐ Oral history (does not include medical history)
- ☐ Placebo
- ☐ Pregnancy testing
- ☐ Program Protocol (Umbrella Protocol)
- ☐ Radiation (e.g., CT or DEXA scans, X-rays, nuclear medicine procedures) → Complete **Appendix V**
- ☐ Randomization
- ☐ Record review (which may include PHI)
- ☐ Specimen research
- ☐ Stem cell research
- ☐ Storage of biological materials → Complete **Appendix H** (future unspecified use, including repositories)
- ☐ Surgical procedures (including biopsies)
- X Surveys, questionnaires, or interviews (one-on-one)
- ☐ Surveys, questionnaires, or interviews (group)
- ☐ Other

Specify: _____

## 18. DURATION

Estimate the time required from each participant, including individual interactions, total time commitment, and long-term follow-up, if any.

This is a single survey, taking approximately 20-30 minutes time in length, depending on the extent of the free text answers.

## 19. NUMBER OF PARTICIPANTS

***The number of participants is defined as the number of individuals who agree to participate (i.e., those who provide consent or whose records are accessed, etc.) even if all do not prove eligible or complete the study. The total number of research participants may be increased only with prior IRB approval.***

a. Provide the total number of participants (or number of participant records, specimens, etc.) for whom you are seeking Ohio State University IRB approval. 120

b. Explain how this number was derived (e.g., statistical rationale, attrition rate, etc.).

List of nursing managers obtained from Mary Nash's office, Chief Nurse Executive.

List of business managers obtained from Chief Nursing Officers.

c. Is this a multi-site study? ☐ Yes → Indicate the total number of participants to be enrolled across all sites: _____

X No

## 20. PARTICIPANT POPULATION

a. Specify the age(s) of the individuals who may participate in the research:

Age(s): **18 and above**

b. Specify the participant population(s). Check all that apply:

X Adults

☐ Children (< 18 years) → Complete **Appendix I**

☐ Adults with decisional impairment → Complete **Appendix W**

☐ Non-English speaking → Complete **Appendix J**

☐ Student research pools (e.g., psychology, linguistics)

☐ Pregnant women/fetuses → Complete **Appendix K**

***Do not complete Appendix K unless pregnant women will be intentionally recruited and/or studied.***

☐ Neonates (uncertain viability/nonviable) → Complete **Appendix K**

☐ Prisoners → Complete **Appendix L**

☐ Unknown (e.g., secondary use of data/specimens, non-

Specify: _____ targeted surveys, program protocols)

c. Describe the characteristics of the proposed participants, and explain how the nature of the research requires/justifies their inclusion.

All participants will be nursing or business administrators or managers at OSUWMC. The survey will identify any administrators or managers that do not currently work with APNs and will be asked to check "no" and exit the survey.

d. Will any participants be excluded based on age, gender, race/ethnicity, pregnancy status, language, education, or financial status? ☐ Yes X No

**If Yes** → Explain the criteria and reason(s) for each exclusion. ***Consider the study's scientific or scholarly aims and risks.***

e. Are any of the participants likely to be vulnerable to coercion or undue influence? ***Consider students, employees, terminally ill persons, or others who may have limited autonomy.*** X Yes No

**If Yes** → Describe additional safeguards to protect participants' rights and welfare. ***Consider strategies to ensure voluntary participation.***

Participants are contacted via OSUWMC email. They are given the choice to participate voluntarily and the survey is anonymous.

## 21. PARTICIPANT IDENTIFICATION, RECRUITMENT, & SELECTION

a. Provide evidence that you will be able to recruit the necessary number of participants to complete the study.

There are no exclusion criteria.

b. Describe how potential participants will be identified (e.g., advertising, individuals known to investigator, record review, etc.). Explain how investigator(s) will gain access to this population, as applicable.

The participants will be identified by using an email listing of business and nursing administrators and managers at OSUWMC. The list of nursing managers will be obtained from Mary Nash's office, Chief Nurse Executive.

The list of business managers will be obtained from Chief Nursing Officers.

c. List the names of investigator(s) and/or key personnel who will recruit participants. The survey will identify any administrators that do not currently work with APNs and will be asked to check "no" and exit the survey.

Shannon Linder, the doctoral student for this project, will contact the nursing and business administrators and managers via their OSUWMC email to introduce the survey. The survey will be accessed via the Internet.

d. Describe the process that will be used to determine participant eligibility.

The participants will be identified by using an email listing of nursing and business administrators and managers at OSUWMC.

e. Describe the recruitment process; including the setting in which recruitment will take place. ***Provide copies of proposed recruitment materials (e.g., ads, flyers, website postings, recruitment letters, and oral/written scripts).***

A list of nursing and business administrators' and managers' work email addresses will be provided to the researcher by nursing administration at OSUWMC for the main hospital, the Ross, the James, and East. The survey will be emailed to the administrators via their work email address with a link to the online checkbox to complete the survey anonymously. A second email with the link to the survey will be sent one week after the original email reminding the potential participants to please complete the survey.

f. Explain how the process respects potential participants' privacy.

Surveys are anonymous and voluntary.

## 22. INCENTIVES TO PARTICIPATE

Will participants receive compensation or other incentives (e.g., free services, cash payments, gift certificates, parking, classroom credit, travel reimbursement) to participate in the research study? ***Compensation plans should be pro-rated (not contingent upon study completion) and should consider participant withdrawals, as applicable.***

☐ Yes
X No

**If Yes →** Describe the incentive, including the amount and timing of all payments.

## 23. ALTERNATIVES TO STUDY PARTICIPATION

Other than choosing not to participate, list any specific alternatives, including available procedures or treatments that may be advantageous to the subject.

N/a

## 24. INFORMED CONSENT PROCESS

Indicate the consent process(es) and document(s) to be used in the study. Check all that apply. ***Provide copies of documents and/or complete relevant appendices, as needed. See Consent for Research for templates, HRPP policies Informed Consent Process and the Elements of Informed Consent, Documentation of the Informed Consent Process, and Assent and Parental Permission or contact ORRP for more information.***

- ☐ Assent – Form
- ☐ Assent – Verbal Script
- ☐ Informed Consent – Form
- ☐ Informed Consent – Verbal Script → Complete **Appendix M2**
- ☐ Informed Consent – Addendum
- ☐ Parental Permission – Form
- ☐ Parental Permission – Verbal Script → Complete **Appendix M2**
- ☐ Translated Consent/Assent – Form(s) → Complete **Appendix J**
- ☐ Waiver or Alteration of Consent Process → Complete **Appendix M1**
- X Waiver of Consent Documentation → Complete **Appendix M2**

b. List the names of investigator(s) and/or key personnel who will obtain consent from participants or their legally authorized representatives. ☐ N/A

Shannon Linder, doctoral student on the project will be sending the email with the link to the survey. The participants will be

agreeing to consent when the click on the online survey. This information will be provided to them in the original and follow-up email.

c. Who will provide consent or permission (i.e. participant, legally authorized representative, parent and/or guardian)? ☐ N/A

Participant.

d. Describe the consent process. Explain when and where consent will be obtained and how subjects and/or their legally authorized representatives will be provided sufficient opportunity (e.g., waiting period, if any) to consider participation. ☐ N/A

The participant will be agreeing to consent for the survey when they click on the online survey. This information will be provided to the participants in the original and follow-up emails. Therefore, the consent will be completed prior to starting the survey. They will "sign" the consent form by clicking the radio button "yes, I consent to participate in the survey," and will be taken to the online link for the survey completion.

e. Explain how the possibility of coercion or undue influence will be minimized in the consent process. X N/A

f. Will any other tools (e.g., quizzes, visual aids, information sheets) be used during the consent process to assist participant comprehension?

☐ Yes → ***Provide copies of these tools***

X No

g. Will any other consent forms be used (e.g., for clinical procedures such as MRI, surgery, etc. and/or consent forms from other institutions)?

☐ Yes → ***Provide copies of these forms***

X No

## 25. PRIVACY OF PARTICIPANTS

a. Describe the provisions to protect the privacy interests of the participants. ***Consider the circumstances and nature of***

***information to be obtained, taking into account factors (e.g., age, gender, ethnicity, education level, etc.) that may influence participants' expectations of privacy.***

The surveys are anonymous and voluntary.

b. Does the research require access to personally identifiable private information? Yes

X No

**If Yes** → Describe the personally identifiable private information involved in the research. List the information source(s) (e.g., educational records, surveys, medical records, etc.).

The surveys are anonymous; however, the participants will be asked if they are a nurse or not a nurse. There will not be any other additional information collected.

## 26. CONFIDENTIALITY OF DATA

a. Explain how information is handled, including storage, security measures (as necessary), and who will have access to the information. Include both electronic and hard copy records. ***Methods for handling and storing data (including the use of personal computers and portable storage devices) must comply with university policies. For more information, see Policy on Institutional Data and Research Data Policy.***

**Participants' answers to survey questions and the anonymous. Only project investigators and co-investigators transcribing and analyzing data will have access to the information from the surveys.**

b. Explain if any personal or sensitive information that could be potentially damaging to participants (e.g., relating to illegal behaviors, alcohol or drug use, sexual attitudes, mental health, etc.) will be collected. X N/A

c. Will you be obtaining an NIH Certificate of Confidentiality? ☐ Yes → ***Provide a copy before you begin the research***

X No

***See* Error! Hyperlink reference not valid.*HRPP policy Privacy and Confidentiality for more information.***

d. Explain any circumstances (ethical or legal) where it would be necessary to break confidentiality. X N/A

e. Indicate what will happen to identifiable data at the end of the study. ***Primary research data should be retained for a minimum of five years after final project closeout. For more information, see the university's Research Data Policy. Other research-related records should be retained for a period of at least three years after the research has been discontinued (i.e., no further data collection, long term follow-up, re-contact, or analysis of identifiable/coded data.)***

X Identifiable data were not collected

☐ Identifiers will be permanently removed from the data and destroyed (resulting in de-identified data)

☐ Identifiable or coded/linked data will be retained and stored securely (as appropriate)

☐ Identifiable data will be retained and may be made public with participant consent (e.g., ethnographic research)

## 27. HIPAA RESEARCH AUTHORIZATION

Will individually identifiable Protected Health Information (PHI) subject to the HIPAA Privacy Rule requirements be accessed, used, or disclosed in the research study?

X No

☐ Yes → Check all that apply:

- ☐ Written Authorization → ***Provide a copy of the Authorization Form***
- ☐ Partial Waiver (recruitment purposes only) →Complete **Appendix N**
- ☐ Full Waiver (entire research study) → Complete **Appendix N**
- ☐ Alteration (written documentation) → Complete **Appendix N**

## 28. REASONABLY ANTICIPATED BENEFITS

a. List the potential benefits that participants may expect as a result of this research study. State if there are no direct benefits to individual participants. ***Compensation is not to be considered a benefit.***

There are no direct benefits.

b. List the potential benefits that society and/or others may expect as a result of this research study.

As a result of this study, there is potential benefit in understanding the administrator knowledge of APN barriers to practice, role, and satisfaction.

## 29. RISKS, HARMS, & DISCOMFORTS

a. Describe all reasonably expected risks, harms, and/or discomforts that may apply to the research. Discuss severity and likelihood of occurrence. As applicable, include potential risks to an embryo or fetus if a woman is or may become pregnant. ***Consider the range of risks, including physical, psychological, social, legal, and economic***.

There are no risks or harms.

b. Describe how risks, harms, and/or discomforts will be minimized. ***If testing will be performed to identify individuals who may be at increased risk (e.g., pregnant women, individuals with HIV/AIDS, depressive disorders, etc.), address timing and method of testing; include how positive test results will be handled.***

There are no risks or harms.

## 30. MONITORING

Does the research involve greater than minimal risk (i.e., are the harms or discomforts described in Question #29 beyond what is ordinarily encountered in daily life or during the performance of routine physical or psychological tests)? ☐ Yes X No

**If Yes** → Describe the plan to oversee and monitor data collected to ensure participant safety and data integrity. Include the following:

- The information that will be evaluated (e.g., incidence and severity of actual harm compared to that expected);
- Who will perform the monitoring (e.g., investigator, sponsor, or independent monitoring committee);
- Timing of monitoring (e.g., at specific points in time, after a specific number of participants have been enrolled); and
- Decisions to be made as a result of the monitoring process (e.g., provisions to stop the study early for unanticipated problems).

## 31. ASSESSMENT OF RISKS & BENEFITS

Discuss how risks to participants are reasonable when compared to the anticipated benefits to participants (if any) and the importance of the knowledge that may reasonably be expected to result.

There are no risks or harms.

## 32. PARTICIPANT COSTS/REIMBURSEMENTS

a. List any potential costs participants (or their insurers) will incur as a result of study participation (e.g., parking, study drugs, diagnostic tests, etc.).

There are no associated costs to participants.

b. List any costs to participants that will be covered by the research study.

There are no associated costs to participants.

## 33. APPLICATION CONTENTS

Indicate the documents being submitted for this research project. Check all appropriate boxes.

- ☒ **Initial Review of Human Subjects Research Application**
- ☐ Appendix A1: Ohio State University Co-Investigators & Key Personnel (questions 4 & 5)
- ☐ Appendix A2: External (non-Ohio State) Co-Investigators & Key Personnel (question 6)
- X Appendix B: Expedited Review – Initial Review (question 13)
- ☐ Appendix C: Data Repositories (question 17b)
- ☐ Appendix D: Deception (question 17b)
- ☐ Appendix E: Devices (question 17b)
- ☐ Appendix F: Drugs or Biologics (question 17b)
- ☐ Appendix G: Genetic Testing (question 17b)
- ☐ Appendix H: Storage of Biological Materials (question 17b)
- ☐ Appendix I: Children (question 20b)
- ☐ Appendix J: Non-English Speaking Participants (questions 20b and 24a)
- ☐ Appendix K: Pregnant Women/Fetuses/Neonates (question 20b)
- ☐ Appendix L: Prisoners (question 20b)
- ☐ Appendix M1: Waiver or Alteration of Consent Process (questions 17b & 24a)
- ☐ Appendix M2: Waiver of Consent Documentation (question 24a)
- ☐ Appendix N: Waiver or Alteration of HIPAA Research Authorization (question 27)
- ☐ Appendix U: Research in International Settings (question 12)

- ☐ Appendix V: Radiation (question 17b)
- ☐ Appendix W: Adults with Decisional Impairment (question 20b)
- ☐ Consent form(s), Assent Form(s), Permission Form(s), and Verbal Script(s), including translated documents (question 24a)
- ☐ HIPAA Research Authorization Form(s) (question 27)
- ☐ Data Collection Form(s) for Investigator-Initiated Studies (question 17a)
- ☐ Data Collection Form(s) involving protected health information (Appendix N)
- ☐ Recruitment Materials (e.g., ads, flyers, telephone or other oral script, radio/TV scripts, internet solicitations) (question 21d)
- ☐ Script(s) or Information Sheet(s), including Debriefing Materials (question 24)
- ☐ Instruments (e.g., questionnaires or surveys to be completed by participants) (question 17b)
- ☐ Other Committee Approvals/Letters of Support (questions 11 & 12)
- ☒ Research Protocol
- ☐ Complete Grant Application or Funding Proposal, as applicable
- ☐ Drug Manufacturer's Approved Labeling/Investigator's Drug Brochure (Appendix F)
- ☐ Device Manufacturer's Approved Labeling (Appendix E)
- ☐ Other supporting documentation and/or materials

**For Multi-Site Clinical Trials supported by DHHS, the submission will also include:**

- ☐ DHHS-approved Sample Informed Consent Document (if one exists)
- ☐ DHHS-approved Protocol (if one exists)

## 34. ASSURANCE

**PRINCIPAL INVESTIGATOR (or Advisor)**

I agree to follow all applicable federal regulations, guidance, state and local laws, and university policies related to the protection of human subjects in research, as well as professional practice standards and generally accepted good research practices for investigators, including, but not limited to, the responsibilities described in HRPP policy *Responsibilities of Principal Investigators, Co-Investigators and Key Personnel*.

I verify that the information provided in this Initial Review of Human Subjects Research application is accurate and complete. I will initiate this research only after having received notification of final IRB approval.

Signature of Principal Investigator (or Advisor) _____ Date _____

Printed name of Principal Investigator (or Advisor) _____

**DEPARTMENT CHAIR (or Signatory Official)**

As Department Chair (or Signatory Official) for the Principal Investigator, I acknowledge that this research is in keeping with the standards set by our unit and that it has met all Departmental/College requirements for review.

***If the PI or any co-investigator is also the Department Chair, the signature of the Dean or other appropriate Signatory Official, such as the Associate Dean for Research, must be obtained.***

Signature of Department Chair

Date

Administrator Perceptions of Advanced Practice Nursing Barriers to Practice Survey

Email Script

Dear administrator/manager,

You are being asked to participate in a study because you are an administrator or manager in an academic medical center setting. The purpose of the study is to assess administrator's perceptions of APN s job satisfaction and barriers to practice.

This survey will take approximately 20-30 minutes to complete. Responses to this survey will be shared with senior nursing and medical leadership. We also plan to disseminate findings from this survey research.

Anticipated benefits from participation in the study may include a better understanding of administrators' perception of APN practice barriers and APNs may benefit by understanding the administrators' knowledge of APN barriers to practice, role, and job satisfaction. There are no identified risks or harms associated with participation in this study.

Your completion of this survey is voluntary and anonymous. Your name will not be on the survey. Completion of the online survey will be considered your consent to participate. All answers, including demographic information, are optional. Completion of the entire survey is greatly appreciated. However, there is a possibility to skip questions or withdraw your participation from the survey without any penalty. There are no right or wrong answers. You can stop at any time or refuse to participate without penalty or loss of benefits to which you are otherwise entitled.

Your data will be protected with a code to reduce the risk that other people can view the responses. We will work to make sure that no one sees your survey responses without approval. But, because we are using the Internet, there is a chance that someone could access your online responses without permission.

For questions about the research, or if you feel you have been harmed by taking part in the study, please contact Dr. Margaret Graham at 614-688–4984.

For questions about your rights as a research participant, or to talk to someone who is not a member of the research team, please contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251.

The survey will remain open for 2 weeks, until the deadline date of *.

We appreciate your time.

Principal Investigator

Margaret Graham, PhD, RN, FNP, PNP, FAANP, FAAN

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Appendix C

**ADMINISTRATION SURVEY REGARDING APN PROFESSION**

**The following statements address your role as an administrator and your experience with the advanced practice nurse (APN) profession in your department. APNs include: certified nurse practitioners, certified clinical nurse specialists, nurse anesthetists, and nurse midwives.**

**Do you have an APN(s) in your department?**

☐ Yes

☐ No

☐ Unsure

**If you do not have an APN(s) in your department, please complete the above question, and you may exit the survey.**

**Please click the number that best describes your agreement or disagreement with each statement. There is no right or wrong answer.**

*SD = strongly disagree, MD = moderately disagree, SLD = slightly disagree, NAD = neither agree or disagree, SLA = slightly agree, MA = moderately agree, SA = strongly agree, IDK= I do not know*

| | SD | MD | SLD | NAD | SLA | MA | SA | IDK |
|---|---|---|---|---|---|---|---|---|
| 1. The APNs in my department are currently able to practice to their full scope of practice allowable by the Ohio law. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 2. I believe that the physician colleagues are supportive of the APN role in my department. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 3. I believe that the physician colleagues understand the APN role. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 4. I believe I understand the APN role. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 5. The APN's job satisfaction is related to how APNs are able to practice in their role. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 6. There are multiple barriers in the APNs practice environment which keeps the APN from practicing to their full scope. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 7. I believe the nurse colleagues in my department are supportive of APNs in my department. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 8. I believe I am supportive of the APN role. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9. I believe that if the APNs were allowed to take on more responsibility under their scope of practice that patient outcomes would be further improved. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

**How satisfied do you believe the APNs in your department are with their current job as an advanced practice nurse (APN) with respect to each of the following factors?**

*VS = very satisfied, S = satisfied, MS = minimally satisfied, MD = minimally dissatisfied, D = dissatisfied, VD = very dissatisfied, UK = unknown*

**Remuneration**

| | VS | S | MS | MD | D | VD | UK |
|---|---|---|---|---|---|---|---|
| 10. Vacation/leave policy | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 11. Benefit package | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 12. Retirement plan | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 13. Support for continuing education (paid conference time and financial monies allowable through OSU for continuing education) | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 14. Recognition of their work from superiors | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 15. Recognition of their work from peers | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 16. Monetary bonuses that are available in addition to their salary | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 17. Opportunity to receive compensation for services performed outside their normal duties | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| **Time allotted for job responsibilities** | | | | | | | |
| 18. Time allotted for answering messages | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 19. Time allotted for review of lab and other test results | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 20. Percentage of time spent in direct patient care | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 21. Time allocation for seeing patient(s) | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| **Working with others** | | | | | | | |
| 22. Amount of administrative support | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 23. Their immediate supervisor | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 24. Quality of assistive personnel | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 25. Professional interaction with other disciplines | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 26. Interaction with other APNs including faculty | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 27. Process used in conflict resolution | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| **Work environment** | | | | | | | |
| 28. Patient scheduling policies and practices | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 29. Patient mix | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 30. Sense of accomplishment | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 31. Ability to deliver quality care | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 32. Amount of consideration given to their personal needs | 6 | 5 | 4 | 3 | 2 | 1 | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 33. Flexibility in practice protocols | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 34. Respect for their opinion | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 35. Acceptance and attitudes of referring physicians, outside of their practice | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| **Professional growth** | | | | | | | |
| 36. Amount of involvement in research | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 37. Opportunity to expand their scope of practice | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 38. Time to serve on professional committees | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 39. Input into organizational policy | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 40. Freedom to question decisions and practices | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 41. Expanding skill level/procedures within their scope of practice | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 42. Opportunities to expand their scope of practice | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 43. Time to seek advanced education | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 44. Level of autonomy | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 45. Evaluation process and policy | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 46. Opportunity to develop and implement ideas | 6 | 5 | 4 | 3 | 2 | 1 | 0 |
| 47. Support for advancing APN education to the doctorate level (DNP or PhD) | 6 | 5 | 4 | 3 | 2 | 1 | 0 |

48. Please describe what you believe is the most satisfying aspect of the APN position within your department. (Free text)

49. Please describe what you believe is the least satisfying aspect of the APN position within your department. (Free text)

50. What is the biggest barrier to you being able to improve satisfaction of APNs in your department? (Free text)

51. Which type of APN are you most familiar working with (select all that apply)?

☐ CNP (certified nurse practitioner)

☐ CNS (clinical nurse specialist)

☐ CRNA (certified registered nurse anesthetist)

☐ CNM (certified nurse midwife)

☐ I work with an APN but I am unsure what his/her title is

52. Which position are you currently in?

☐ Business administrator

☐ Nursing administrator

☐ Executive administrator

☐ Other: (Free text)

53. Does the standard care arrangement with the APN in your department and their collaborating physician facilitate the APN's practice in positive ways?

☐ Yes

☐ No. If not, why not? (Free text)

☐ I am unfamiliar with the standard care arrangement and/or have no involvement with this

54. Does the APN Privilege Form meet the APN's practice needs in your department?

☐ Yes

☐ No. If not, why not? (Free text)

☐ I am unfamiliar with the privilege form and/or have no involvement with this

55. What is your department's primary patient population?

☐ Acute Care

☐ Adult

☐ Family

☐ Geriatrics

☐ Mental Health

☐ Neonatal

☐ Women's Health

☐ Other: (free text)

56. If you have a secondary specialty please indicate: (free text)

57. Which facility do you and your department's APNs primarily work (select all that apply)?

- ☐ Dodd
- ☐ Float
- ☐ James Ambulatory
- ☐ James Inpatient
- ☐ OSU Ambulatory facility
- ☐ OSU East
- ☐ Ross
- ☐ UH
- ☐ Other: (free text)

58. Are the APNs in your department:

- ☐ Inpatient
- ☐ Outpatient
- ☐ Both

59. How many patients do the APNs working in your department care for in a typical day? (free text)

60. Are the APNs in your department satisfied with the amount of time they are able to spend with patients?

- ☐ Yes
- ☐ No. If not, please describe why? (free text)

61. Do the APNs in your department bill for their services?

- ☐ Yes
- ☐ No

☐ Other: (Free text)

62. If the APNs bill for their services, do they bill:

☐ Incident to

☐ Under their own billing number

☐ Both incident to and under their own billing number

☐ Subsequent hospital visit

☐ Critical care time

☐ Procedure billing

☐ All shared visits with physician

☐ Both shared visits and independent

☐ N/A – do not bill

63. Do you have any comments or concerns about APN billing? (free text)

64. Do you feel the APNs in your department have any concerns about their billing and if so please elaborate? (free text)

65. What is your highest level of education completed?

☐ Associates

☐ Bachelors

☐ Masters

☐ Doctorate

66. How many years have you worked as an administrator? (Free text)

67. How many years have you worked with APNs at OSUWMC? (Free text)

68. Do you feel the APNs in your department were you satisfied with their orientation they received to their current role?

☐ Yes

☐ No. If not, please share why you believe they were not satisfied and what could be done to improve it. (free text)

69. How are the APNs in your department employed?

☐ 100% by the University/Medical Center

☐ 100% by OSUP

☐ Split between OSU and OSUP

☐ Unknown

☐ Other: (Free text)

70. Which employer provides benefits to the APNs in your department?

☐ 100% by the University/Medical Center

☐ 100% by OSUP

☐ Split between OSU and OSUP

☐ Unknown

☐ Other: (Free text)

71. If the APNs in your department are employed by OSUP, are you aware of the differences in benefits between OSUP and OSU (ie paid time off and lack of tuition reimbursement)?

☐ Yes

☐ No

☐ n/a (the APNs in my department are hired by OSU)

72. Who does the annual evaluation (P3) of the APNs in your department?

☐ Nursing director/manager

☐ Physician

☐ Non-clinician administrator

☐ Other: (Free text)

73. Does the APN in your department directly report to you?

☐ Yes

☐ No

74. If the APN in your department does not report to you, who does the APN in your department directly report to?

☐ A registered nurse manager

☐ An APN

☐ A physician

☐ A non-clinician administrator

☐ Other: (Free text)

☐ N/A; the APN in my department directly reports to me

75. Do you feel there are any concerns about the current reporting structure?

☐ No

☐ Yes. If yes, what concerns you? (free text)

Demographics (completion of some or all of the following items is optional)

76. Please indicate how long you have been in a management or administrative role:

☐ 0-5 years

☐ 6-10 years

☐ 11-15 years

☐ 16-20 years

☐ 20+ years

77. Please indicate if you are a nurse:

☐ Yes

☐ No

Appendix D

Table 1

***Summary statistics for the questionnaire items grouped by category***

| | | | *All* | | |
|---|---|---|---|---|---|
| | *Sample size* | *Mean* | *STD* | *Minimum* | *Maximum* |
| *Barriers (9 items)** | 23 | 5.42 | 0.74 | 3.89 | 7.00 |
| *Remuneration (8 items)* | 13 | 4.32 | 0.60 | 3.50 | 5.33 |
| *Time allotted (4 items)* | 17 | 4.49 | 1.12 | 2.75 | 6.00 |
| *Working with others (6 items)* | 17 | 4.35 | 0.77 | 2.00 | 5.20 |
| *Work environment (8 items)* | 16 | 4.46 | 0.84 | 2.25 | 6.00 |
| *Professional growth (12 items)* | 15 | 3.94 | 1.02 | 1.91 | 5.73 |

***For a subject to be included in the sample for a group, he/she had to respond to at least half of the items in a group***

****With Barriers6 reverse coded using the following transformation: new Barriers6 = 8 – old Barriers6.***

***Note: Responses of '8' (IDK) were treated as missing***

Table 2

***Summary statistics for the 9 'Barriers' items.***

| | *Sample size* | *Mean* | *STD* | *Minimum* | *Maximum* |
|---|---|---|---|---|---|
| *Barriers1* | 22 | 4.41 | 2.02 | 1.00 | 7.00 |
| *Barriers2* | 22 | 5.27 | 1.32 | 3.00 | 7.00 |
| *Barriers3* | 21 | 4.10 | 1.84 | 1.00 | 7.00 |
| *Barriers4* | 23 | 6.39 | 0.94 | 3.00 | 7.00 |
| *Barriers5* | 20 | 6.35 | 1.42 | 1.00 | 7.00 |
| *Barriers6* | 22 | 2.45 | 1.34 | 1.00 | 6.00 |
| *Barriers7* | 20 | 6.25 | 1.25 | 2.00 | 7.00 |
| *Barriers8* | 21 | 6.81 | 0.51 | 5.00 | 7.00 |
| *Barriers9* | 22 | 6.55 | 0.96 | 3.00 | 7.00 |

*Barriers6 is reverse coded

***For the statistics computed above, a response of 8 was treated as missing.***

Appendix E

***Distribution of responses for the choice items. Responses have been ordered by their frequency of response.***

| *Choice item* | *N* | *Response* | *Frequency* | *Percent (of the not missing)* |
|---|---|---|---|---|
| *Type* | *23* | *CNP CNS* | *8* | *38.10* |
| | *.* | *CNP* | *7* | *33.33* |
| | *.* | *CNP CNS CRNA* | *2* | *9.52* |
| | *.* | *CNS* | *2* | *9.52* |
| | *.* | *CNP CRNA* | *1* | *4.76* |
| | *.* | *CRNA* | *1* | *4.76* |
| | *.* | *Missing* | *2* | *.* |
| | | | | |
| *Position* | *23* | *Nursing* | *14* | *77.78* |
| | *.* | *Business* | *2* | *11.11* |
| | *.* | *Executive* | *2* | *11.11* |
| | *.* | *Missing* | *5* | *.* |
| | | | | |
| *Arrangement* | *23* | *Yes* | *14* | *70.00* |
| | *.* | *Unfamiliar* | *5* | *25.00* |
| | *.* | *No* | *1* | *5.00* |
| | *.* | *Missing* | *3* | *.* |
| | | | | |
| *Priviledge* | *23* | *Unfamiliar* | *11* | *55.00* |
| | *.* | *Yes* | *9* | *45.00* |
| | *.* | *Missing* | *3* | *.* |
| | | | | |
| *Population* | *23* | *Acute* | *5* | *26.32* |

| *Choice item* | *N* | *Response* | *Frequency* | *Percent (of the not missing)* |
|---|---|---|---|---|
| | . | *Adult* | *5* | *26.32* |
| | . | *Acute Adult* | *4* | *21.05* |
| | . | *Acute Adult Geriatrics* | *1* | *5.26* |
| | . | *Adult Mental* | *1* | *5.26* |
| | . | *Family* | *1* | *5.26* |
| | . | *Mental* | *1* | *5.26* |
| | . | *Women* | *1* | *5.26* |
| | . | *Missing* | *4* | . |
| | | | | |
| *Facility* | *23* | *UH* | *5* | *26.32* |
| | . | *OSU_East* | *3* | *15.79* |
| | . | *James_Amb* | *2* | *10.53* |
| | . | *James_In* | *2* | *10.53* |
| | . | *Dodd OSU_Am UH* | *1* | *5.26* |
| | . | *Dodd Ross UH* | *1* | *5.26* |
| | . | *James_In OSU_Am OSU_East Ross UH* | *1* | *5.26* |
| | . | *James_In UH* | *1* | *5.26* |
| | . | *OSU_Am* | *1* | *5.26* |
| | . | *OSU_East UH* | *1* | *5.26* |
| | . | *Ross* | *1* | *5.26* |
| | . | *Missing* | *4* | . |
| | | | | |
| *Patient* | *23* | *Both* | *11* | *52.38* |
| | . | *Inpatient* | *6* | *28.57* |
| | . | *Outpatient* | *4* | *19.05* |
| | . | *Missing* | *2* | . |
| | | | | |

| *Choice item* | *N* | *Response* | *Frequency* | *Percent (of the not missing)* |
|---|---|---|---|---|
| *Satisfied* | *23* | *Yes* | *11* | *61.11* |
| | *.* | *No* | *7* | *38.89* |
| | *.* | *Missing* | *5* | *.* |
| | | | | |
| *Bill* | *23* | *No* | *10* | *66.67* |
| | *.* | *Yes* | *5* | *33.33* |
| | *.* | *Missing* | *8* | *.* |
| | | | | |
| *Howbill* | *23* | *DoNotBill* | *6* | *37.50* |
| | *.* | *BothAllSharedIndependent* | *3* | *18.75* |
| | *.* | *BothIncidentUnder* | *2* | *12.50* |
| | *.* | *Incident_to* | *2* | *12.50* |
| | *.* | *Procedure* | *2* | *12.50* |
| | *.* | *Under_own* | *1* | *6.25* |
| | *.* | *Missing* | *7* | *.* |
| | | | | |
| *Education* | *23* | *Bachelors* | *10* | *47.62* |
| | *.* | *Masters* | *10* | *47.62* |
| | *.* | *Doctorate* | *1* | *4.76* |
| | *.* | *Missing* | *2* | *.* |
| | | | | |
| *Orientation* | *23* | *Yes* | *15* | *83.33* |
| | *.* | *No* | *3* | *16.67* |
| | *.* | *Missing* | *5* | *.* |
| | | | | |
| *Employed* | *23* | *University* | *8* | *38.10* |
| | *.* | *Split* | *7* | *33.33* |

| *Choice item* | *N* | *Response* | *Frequency* | *Percent (of the not missing)* |
|---|---|---|---|---|
| | . | *Unknown* | *4* | *19.05* |
| | . | *University Split* | *1* | *4.76* |
| | . | *University Unknown* | *1* | *4.76* |
| | . | *Missing* | *2* | . |
| | | | | |
| *Benefits* | *23* | *University* | *13* | *61.90* |
| | . | *Split* | *5* | *23.81* |
| | . | *Unknown* | *3* | *14.29* |
| | . | *Missing* | *2* | . |
| | | | | |
| *Differences* | *23* | *NA* | *10* | *52.63* |
| | . | *Yes* | *5* | *26.32* |
| | . | *No* | *4* | *21.05* |
| | . | *Missing* | *4* | . |
| | | | | |
| *Evaluations* | *23* | *Nursing* | *12* | *75.00* |
| | . | *Physician* | *2* | *12.50* |
| | . | *Nonclinician* | *1* | *6.25* |
| | . | *Nursing Physician* | *1* | *6.25* |
| | . | *Missing* | *7* | . |
| | | | | |
| *Reporting* | *23* | *No* | *15* | *71.43* |
| | . | *Yes* | *6* | *28.57* |
| | . | *Missing* | *2* | . |
| | | | | |
| *Who* | *23* | *APN* | *7* | *46.67* |
| | . | *NA* | *5* | *33.33* |

| *Choice item* | *N* | *Response* | *Frequency* | *Percent (of the not missing)* |
|---|---|---|---|---|
| | . | *Nonclinician* | *2* | *13.33* |
| | . | *Nurse APN Physician* | *1* | *6.67* |
| | . | *Missing* | *8* | . |
| *Concerns* | *23* | *Yes* | *16* | *80.00* |
| | . | *No* | *4* | *20.00* |
| | . | *Missing* | *3* | . |
| *Length* | *23* | *0 to 5* | *7* | *33.33* |
| | . | *11 to 15* | *4* | *19.05* |
| | . | *20+* | *4* | *19.05* |
| | . | *6 to 10* | *4* | *19.05* |
| | . | *16 to 20* | *2* | *9.52* |
| | . | *Missing* | *2* | . |
| *Nurse* | *23* | *Yes* | *17* | *80.95* |
| | . | *No* | *4* | *19.05* |
| | . | *Missing* | *2* | . |

***For several of the items (for example patient population), multiple responses were checked by some subjects even though 'select all that apply' was not in the item stem.***